OUT-PATIENT CLAIM FORM

Practitioners Name Dr. FirstName2 SecondName2

Practitioner's Official Stamp

Postal Address Nairobi, Kenya

Tel No. 25673133232 Mobile 2567352393332

Email kenyatestuser434@test.ai

PATIENT'S PARTICULARS

Full Name of Patient PFirstName2 PSecondName2 Date of Birth 02/11/1920

Full Name of Member (if patient is a dependant) Specimen2 Sample2

Member's Tel No. 0720000002 Member No. 100002

Member's Employer Name Sample2 Company (K) Ltd Dept. /Branch Department1 Sample1

Have you suffered from this sickness in the past? YES NO

If YES, when did it start and how frequent is it? N/A

CONSULTATION/REFERRALS DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription		Injection given		Dispensed		None	
RADIOLOGY:	X-Ray		MRI/Cat Scan		Other		Other	
PATHOLOGY:	Haematology		Microbiology		Biochemistry		Histology	

Hospital Name: Consultant Referred To: Specialty:

MEDICATION PRESCRIBED:

Sample 1, Sample 11

Dr's Signature TTTTT **Date** 02/10/2023

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature YYYYYY **Date** 01/01/2023

UAP Insurance Company Limited
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